The extended surgical team

How hospitals around the UK are using the extended surgical team to improve patient care.

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The healthcare environment we work in is continually changing. Accordingly, surgical departments have evolved in terms of their structure, personnel and output. Recent developments have been underpinned by increasing patient needs, and moulded by working time regulations, the new junior doctor contract terms and conditions, and chronic understaffing.

How do we best maintain quantity and quality of the service provided to patients while assuring high-quality training for surgical trainees in the system? It is naïve to consider 'service' and 'training' to be mutually exclusive, but few would refute that most tasks lie closer to one end of the spectrum drawn between the two.

With steady evaporation of the classical surgical 'firm' structure and increasingly widespread rota gaps, the make-up of most surgical teams has undergone significant reconfiguration. Without useful change, trainees left in the system will likely remain overstretched to deliver 'service', at the cost of their own surgical 'training' and to the long-term disadvantage of patients. Maintaining the balance is perhaps more tricky than ever. How do we protect continuity?

THE EXTENDED SURGICAL TEAM – A PART OF THE SOLUTION?

Surgical departments around the country have responded in various ways. While all have done their best to improvise in the short term, many have sought to find more definitive solutions. Some have tried to make use of the Extended Surgical Team, in various settings. These include: (to name a few) surgical care practitioners, advanced nurse practitioners, extended scope practitioners and physician associates.

When such roles are developed optimally, they can without a doubt enhance the quality of patient care AND the proportion of time that trainees spend doing work with greater educational value. Practitioners in extended roles can greatly enhance continuity of inpatient ward care. They can facilitate new foundation doctors as they settle into a new specialty and 'iron out' learning curves between rotations.

The use of appropriately trained practitioners can also be greatly advantageous in the outpatient setting by affording more predictable clinic staffing. The regularity of registrar presence is often attenuated by shift working, on-call commitments and the

EST: A surgical care practitioner perspective

As a surgical care practitioner (SCP) and constant member of the team, I provide consistency within the surgical team alongside the consultants. This has the benefit of continuity of care for patients and familiarity with the organisation's workings and the consultant preferences, which I relay to trainee doctors to smooth their transition into the team. As an SCP I provide flexible working to support service needs and enhance junior doctor training by adapting, where possible, my job plan and covering different aspects of the patient pathway. SCPs have different clinical backgrounds. As a nurse with a perioperative background working within a medicalised role, I have insight into the pressures both of nurses and junior doctors in numerous clinical areas and can offer appropriate support. Having different strengths has helped myself and the junior doctors I work with to support each other, build relationships and optimise patient care. I consider that part of my role as an SCP is to support the development and training of the surgeons of the future.

Sara Dalby Surgical Care Practitioner

EST: The consultant perspective

Most surgeons, at some point in their career, will be fortunate enough to work in a unit where one or more extended surgical team members play a critical role. In the past 20 years in the vascular unit at Cheltenham, where there has been a rapid turnover of surgical trainees, we have found that EST roles provide continuity in patient care. Contrary to the fears of many trainees that the presence of these extended roles will detract from training, we've seen educational opportunities increase.

The exact role of the EST member will depend on departmental requirements and we suggest that these are identified early. It is clear from our experience that key factors in successful integration include careful candidate selection, a supervising consultant surgeon 'champion' with clinical, educational and line management responsibility, well-defined training and competency requirements, and the opportunity for professional development and career progression.

We believe that adopting this approach will help teams to embrace both surgical training requirements and the dynamics of surgical team management.

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need to cover rota gaps. After trainees rotate to a new sub-specialty, it takes time to gain familiarity with the presenting pathologies and the best management plans. Practitioners in extended roles present a sustainable solution that reduces the fluctuations in expertise to maintain care standards, and reduces reliance on rotating registrars. These registrars can in turn benefit from a slightly more 'supernumerary' outpatient role alongside a consultant, allowing greater educational value. This has to be better if our system aims to create the best consultants, for patient care, with breadth as well as depth of knowledge.

There can also be benefits in the theatre environment. Owing to the above mentioned factors that impact on trainee availability, many departments can struggle to allocate the necessary number of assistants to run regular theatre lists. The flexibility afforded by having theatre-based practitioners helps fill this void and can also help trainees to fulfill their individual needs. If there are clashing lists, it can help a trainee attend a case where he or she can derive the best marginal training value, rather than assist in an operation he or she may have seen many times before. If the trainee is senior, having an experienced practitioner to assist can give consultants the confidence to supervise unscrubbed, or remotely, which is a key step during the transition towards CCT.

WHAT ARE THE CONCERNS AROUND USE OF THE EXTENDED SURGICAL TEAM?

Some have justifiable concerns about the potential expansion of extended practitioner roles. Some consultants express concern about quality assurance and standard setting for these practitioners. Others question their clinical governance, regulation and accountability. Practitioners themselves have questions regarding support, training and career progression. Both groups have different views on scope of practice. Exactly what tasks should (or should not) be delegated?

From a trainee perspective, some are concerned at the potential further loss of training opportunities. They highlight worrying anecdotes where they have experienced heavy service workloads that have been compounded rather than attenuated by the involvement of practitioners with extended roles. The training phase for these practitioners requires particular consideration; when properly planned this can be achieved without negatively affecting surgical trainees but otherwise there may be unhealthy competition.

The heterogeneity of the roles and the spectrum of needs within departments across the country, means that one size does not fit all. This needs to be recognised when recruiting extended surgical team members. Having seen the potential benefits, and shortfalls, of the roles during the case studies conducted for the Extended Surgical Team report,[1] it seems the following four principles must be realised for these roles to fulfill their potential (see insex box below) If any one of these is lacking, then there may be resultant disadvantages for patient care, training and work satisfaction.

MY PERSONAL EXPERIENCE OF THE EXTENDED SURGICAL TEAM

My personal experience has been very positive. I have come across others who have had negative experiences; all of these have resulted from an obvious shortfall in one of the above principles. In most of these cases, practitioners have been hired to substitute rather than complement trainees (which they themselves do not wish to do!), have been hired without consideration for actual local needs, or there has been poor consultant leadership.

In my current department at Musgrove Park, Taunton, things work well. The extended surgical team members are invaluable to patient care and greatly beneficial to the trainees. The 'trauma coordinator' is essential to the running of the department, coordinating all trauma operations as well as cross-specialty referrals. She also performs clinical tasks including clerking and assessment of hip fracture patients, nerve blocks, cannulation, venepuncture and requesting appropriate investigations. There are ward-based nurse practitioners who are have been assigned to specific teams of consultants (eg lower limb)

Four principles needed for the extended surgical team to work

1. **Roles should be properly planned prior to recruitment**
   Consider all of the following: responsibilities, scope of practice, training, assessment, progression, accountability and sustainability.
2. **Roles should be initiated specifically in response to local departmental needs**
   For instance, if a system primarily needs additional support on the wards or in the outpatient setting then hiring purely theatre-based practitioners would accentuate the imbalance rather than help, and vice versa. Roles should complement, not substitute, trainees.
3. **There must be emotionally intelligent consultant leadership**
   This is necessary to guide the needs and development of non-medical practitioners through mentoring and supervision, while concomitantly ensuring that there is no negative impact on surgical trainees.
4. **Strong departmental training culture**
   Departments should balance the education of surgical trainees (ie future consultants) with service provision, and the most effective non-medical practitioners subscribe to this ethos.

EST: The NHS Employers perspective

With increasing numbers of patients, an ageing population, more frequent comorbidities and changing service models, the need for the expansion and regulation of this group of highly trained and skilled staff has never been greater.

Employers need to develop a different workforce model for the future – one that uses the most efficient mix of available staff to continue to provide the highest-quality care for patients and improve training for our trainees.

The extended surgical team is a key way in which we can do that. Their expansion may also be the catalyst for change that teams need to develop brand new ways of working and providing even better care for our surgical patients.

Sarah Parsons Head of Medical Pay and Workforce, NHS Employers

and optimise the continuity of inpatient patient care. As well as clinical care duties, they coordinate the admission and clerking of all elective surgical patients and also help with discharge paperwork, which means a more favourable ratio of clinical to administrative duties for the rotating foundation doctors.

Core trainees are supernumerary, without ward commitments and spend their time in theatres, clinics and on-call. There are a large number of experienced extended scope practitioners who again are attached to particular teams in the outpatient setting, and allow rotating registrars to see new or complex patients while being supervised by a consultant. This means trainees gain a lot from clinics as opposed to previous placements, where we have often been used as service fodder with little increase in subspecialty expertise over a six-month attachment. The ability for some of the theatre staff to assist in theatre has greatly helped trainees choose which lists to attend to maximise educational benefit. This has been essential to support the consultants to carry out their lists, while also protecting registrar time off to meet contractual requirements.

CONVERSATION IS KEY

Think about how new roles could be used better in your own departments to improve both patient care and training. Initiate discussion with your consultants and feel free to openly agree or completely disagree with anything you have read in this article. What has you experience been? Please do write to the *Bulletin* to tell us about your experiences with the extended surgical team. Tell us about benefits you have experienced, anecdotes where the situation has been worsened, and ways in which you think the system could be improved.

For more information on EST visit www.rcseng.ac.uk/EST. We will also be publishing careers information and guidance later this year. If you have any comments on this piece, please write to bulletin@rcseng.ac.uk.

RCS Accreditation – part 2

The providers listed below have been recognised by the RCS as conforming to their standards of surgical education and training.

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  2 October 2017
  Newcastle Surgical Training Centre
- Right Side Resection Course – day 1 of a 2-day course
  20 July 2017
  WIMAT, Cardiff
- Transanal Total Mesorectal Excision Course
  11-12 October 2017
  ICENI Centre, Colchester
- Parastomal Hernia Course
  5 September 2017
  MATTU, Guildford

RCS SENIOR CLINICAL FELLOWSHIP SCHEME: RECENTLY APPROVED POSTS

- Colchester Laparoscopic Colorectal Fellowship
  The ICENI Centre, Colchester [re-approval]
- The Frimley Park Hip Fellowship
  Frimley Park Hospital NHS Trust [re-approval]

Musgrove Park Post-CCT Fellowship in Bariatric and Benign UGI Surgery
Musgrove Park Hospital, Taunton [re-approval]

RECENTLY ACCREDITED SURGICAL EDUCATION CENTRES

- Incision Academy – online surgical education platform
  https://www.incision.care/

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